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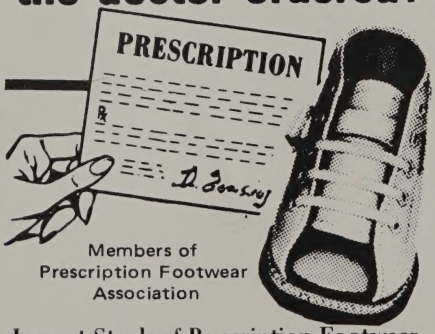

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VOL. XXXII, NO. 1 JANUARY 1976

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Issue Theme: "MERGERS"

The official bulletin
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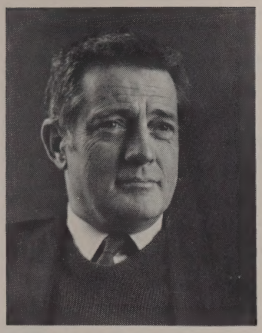

Gardner Cox II, M.D.

Your President's Page

JANUARY THOUGHTS

Fellows:

Hope you all turn out to hear Dr. Alfano talk about Malpractice in Massachusetts at the February HDMS meeting.

As you all know the present available malpractice insurance is through the J.U.A. and by law will be available for two years only. Thereafter there must be some other form of insurance available for the physicians not presently covered to continue to be able to obtain insurance.

It is this that Dr. Alfano is trying to solve and the methods of approach may be well scrutinized by all of us to be sure we approve.

Recently, as a member of the board of directors of HCFWM a coding and criteria manual was sent to me. This is an 800 plus page book compiled by this organization to be made available to all hospitals and coordinators and review bodies in the area. It is a result of many hours of input from western Massachusetts physicians to create a local review of patient care for we who practice in this region. It obviously has required massive cooperation to produce this compilation adjusted to our area. It has been a year in the making and I believe that this is a tremendous track record for production, when the AMA has spent almost three years to produce their manual.

I think that HCFWM should be congratulated for this accomplishment and I think we should feel that our area physicians have done a wonderful job. I hope that all the physicians in the Western Mass. region will find these criteria to be responsible, livable and an aid to them rather than a hindrance as they continue to care for their patients.

Now is the time for constructive problem solving as the difficulties arise rather than destructive, blind criticism.

Gardner Cox II, M.D.
HDMS President

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DISTRICT MEETING

DATE:	*Tuesday, February 3, 1976*
TIME:	*6:00 P.M. Business Meeting*
	7:00 P.M. Social Hour
	7:30 P.M. Dinner (Courtesy of HDMS)
PLACE:	*Storrowton Tavern, Stagecoach Barn*
	West Springfield
SPEAKER:	*Louis F. Alfano, M.D.*
	President
	Massachusetts Medical Society
TOPIC:	*Liability Insurance Program in Massachusetts*

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Philip B. Stoddard, M.D.
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In Memoriam
Norman Yosko, M.D.

Dr. Norman Yosko of 315 N. Main Street, East Longmeadow died Sunday, December 7, 1975 at the Medical Center of Western Massachusetts.

A native of New York City, he lived in East Longmeadow for thirty six years.

Dr. Yosko graduated from Long Island University and received his medical degree from the University of Chicago Medical School. He was on the staff of Ludlow Hospital and the Holyoke Soldier's Home.

Dr. Yosko served in World War II as a Major in the Army Medical Corps. He was also a member of the New York Lodge of Masons, East Longmeadow American Legion and attended B'Nai Jacob Synagogue.

Deepest sympathy is extended to his family, friends and associates.

Editorial Comment:

MERGER

(2) EQUITY: the vesting in one person of two interests in the same right but subject to separate treatment according to equitable demands"
This definition is found on page 1414 of Webster's Third New International Dictionary Unabridged and seems most appropriate for this issue . . . . .

Editor-in-chief

The new year always brings promise of change and expectation. Personal resolves, fiscal years, conquests and losses are all made from that special once a year midnight. Even though the year should probably be 1979 and should only pertain to the world's Christians, most of God's children whoop it up—in one fashion or the other on that night. In those of us past 50, this night holds a special fascination; we know the countdown pertains to us. We are approaching a merger with destiny. So have a happy, joyous new year.

In October 1975, the Springfield Medical and Health Communities were stunned, then bewildered by the announcement that two of the acute bed hospitals in Springfield were contemplating a merger of staff, facilities, budgets and future goals. Your Editor went through the above reactions and then went on to delight. The new year will also see the starting up of the area's HPA, as created by Public Law 93-641. This federal venture into "coordinated and consumer oriented" health care delivery requires much physician input, in spite of the fact that it seems directed against us. It does not pertain to medical practice but health care delivery in a regional concept and scope. The second featured article outlines the law and this paper was read at the last Hampden District Meeting. One of the last major impacts of the now defunct WMHPC was to coordinate an emergency and ambulance plan. The third featured article explains what has been accomplished.

Thus looking back into 1975, your Editor sees that the groundwork for the merger principle was strongly present. In unity there is greater strength and efficiency of operation (up to a point). The second half of the seventh decade holds promise for more of the same, under many guises. We physicians will no longer reign supreme in the area's health care delivery, but that may be for the good. The numerous tasks and chores not directly related to the practice of medicine will now be assumed by third parties; to leave us with the sweet joy of the sole (soul?) practice of medicine. We will be able to return to our patients and our bedside manners should improve. To these new ideas and challenges, we must lend our minds and hearts or be overwhelmed and reduced like the Athenian physicians in Rome.

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I believe it is better to sit in the canoe's bow and guide our careers around the white water obstacles assisted by the third parties in the stern providing the basic direction to left or right and both urged on and downstream by the restless water of consumerism, with all watching for the rapids of political hucksterism, than flounder and/or drown.

Again it is an editorial pleasure to introduce to the membership, seventeen new members of the Hampden District Medical Society. May I urge their sponsors to see that these new faces (now merging with us) come to our district meetings. It is your responsibility to introduce them to organized level a la Hampden. To the new members—Welcome Aboard, if you have any problems in practice contact your president Dr. Cox, the Executive Committee or our gal **Viv.** Your letters to the Editor are welcome and if you have a flare with words, submit them—regardless of the subject. This bulletin is yours. The best Valentine Day's piece of poem or prose will win for its author dinner for two in one of the restaurants which advertise in the Hippocrat—try your hand lads or lasses or persons.

So on into 1976, bicentennials etal.

The Editor-in-chief

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FEATURED ARTICLE:

A Hospital Merger Proposed In October 1975.

The Baystate Medical Center

This past October the Medical Center of Western Massachusetts and Wesson Memorial Hospital announced their intention to merge into one health care complex. The product of this merger, a 1,054 bed teaching and referral center to be known as *Baystate Medical Center,* offers a unique challenge to the 600-member Medical Staff, who, in their concern for their patients and practice of medicine, have contributed to the growth and development of each hospital.

The reasons to merge these two hospitals—each with a distinct history and institutional character—are based on the belief of their trustees that a true consolidation will be the most promising and helpful way to develop the high standards of medical care, education and community service in a cost effective organizational structure, as set forth in a joint statement issued on October 15:

"Obviously, there have been many hours spent on the reasons for this major and momentous decision. In general, we felt that this effort could substantially improve the quality and scope of medical care for the region; that the delivery of health care could be accomplished more economically; that optimum use of buildings and equipment could be achieved; that without a university-based educational institution, the creation of an enlarged medical facility would attract additional professional staff members of the highest caliber and permit the broadening and coordination of our medical, nursing and technical educational programs.

"Some examples of specifics are: the better utilization of existing beds; the coordination of existing services such as emergency units, outpatient clinics and outreach programs; consolidation of already proposed programs of physical expansion now estimated to be in excess of forty million dollars, with the hope of expending less than that amount; the achievement of greater centralization of our mutual health planning efforts and the coordination of our fund raising energies."

The magnitude of the proposed merged institution is reflected in the estimated 1976 statistics for the combined hospitals:

Beds		1,054	
Bassinets		132	
Admissions		42,300	
Outpatients		387,200	
	of which	128,500	are emergencies
		258,700	are not emergencies
Personnel		3,100	
Operating Expenses		$60,100,000	
Assets		$63,600,000	

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"The formation of a health care organization capable of providing quality and personal care within the framework of our projected size and complexity is a job that cannot be done with haste," expressed John E. Mann (then chairman of the board of Medical Center of Western Massachusetts) and Maurice N. Katz, chairman of the board of Wesson Memorial Hospital. "The machinery has already been put into effect with the formation of a **joint consolidation committee,"** they said. This committee is composed of Mr. Maurice N. Katz, chairman of the board at Wesson Memorial Hospital; Mr. Irving A. Quimby, chairman of the board at Medical Center of Western Massachusetts; Mr. Harry C. F. Gifford, president of Medical Center of Western Massachusetts; Mr. Robert F. Tuveson, president of Wesson Memorial Hospital; Robert W. Emery, M.D., president of professional staff at Medical Center of Western Massachusetts; Garry deN. Hough, III, M.D., president of medical staff at Wesson Memorial Hospital; Mr. Herbert Almgren; Mr. Allan A. Campbell; Mr. Graham King; Mr. John E. Mann; Mr. Samuel F. Rockwell, III; Mr. Scott M. Stearns, Jr. and William M. Cloud, M.D. and Robert G. Ernst, M.D., alternates. "The joint committee has the task of establishing a philosophy for this merger," Messrs. Katz and Mann said. "This philosophy must be based on mutual respect and the belief that the interest of the community comes first."

An agreement of merger, dated November 24, 1975, establishes specific guidelines for the consolidation committee to go by, according to the chairmen. The Agreement of Merger's Preamble states:

"The basic reason for merger of Medical Center and Wesson into a single hospital corporation now is the belief of the trustees of both hospitals that this will be the most promising and helpful way to continue to improve the high standards of medical care, education, training and research of both hospitals. It is apparent that both hospitals must coordinate their services and facilities so as to make the most economical use of limited funds in an effort to provide the best possible medical care. It is expected that improvement of administration and economies of operation can be achieved to the benefit of all.

"This merger is entered into in full recognition of the 1974 merger of Wesson Women's Hospital and Springfield Hospital into the Medical Center. That merger contemplated, and subsequent events have confirmed, that the names of each of those hospitals would be maintained separately in some appropriate fashion and the specialties engaged in by each hospital would be treated with due respect. It is now intended that the present merger will follow a similar pattern with three hospital units remaining for an indefinite period of time under the names of Springfield Hospital, Wesson Women's Hospital and Wesson Memorial Hospital, and that hospital activities will be carried on in their present locations for the foreseeable future.

"The resulting hospital will be a single corporation with a single board of trustees, a single administration and a single medical staff, composed initially of the present members of the staff of both hospitals. The current privileges of all staff members will remain in effect following the merger pending review thereof by the joint Board of Trustees. In entering into this transaction, the trustees of both hospitals believe and expect that the special missions and high traditions of excellence of each institution will continue and flourish in an atmosphere of harmony and mutual respect."

Since the ratification of the Agreement of Merger, the Joint Committee on Consolidation has been dealing with a variety of matters, including the writing of bylaws, the selection of trustees, and the preparation of a myriad of legal requirements that must be accomplished for filing with the Secretary of State.

Once the legal requirements have been met, the bylaws developed and trustee selection made—hopefully early this January—the Joint Committee on Consolidation will become involved in the detailed planning of the merger by establishing other subcommittees. These groups will deal with the best ways and means to meld financial matters; how best to use buildings and facilities; how to establish departments most efficiently; and, also, to prepare medical staff bylaws. The subcommittees will report their findings to the Joint Committee on Consolidation. In this capacity both hospitals are looking forward to a large and diverse input from medical staff members.

By all reckoning, the medical staff will face the greatest challenge in its structuring; however, the presidents of the respective staffs chose to see the bright potentials. Dr. Garry deN. Hough, III, president of Wesson Memorial's staff told the Annual Meeting of that hospital's corporation:

"I do not need to impress upon you the importance of this recommendation, and I happen to think it is one of the most important and exciting events that has occurred in the medical community of Springfield in the 20 years that I have been here. Like many other events that suddenly appear, apparently out of nowhere, this has a long background which I am not going to detail for you today. But I would like to point out that the history of cooperation in the medical profession probably does not go back more than 50 or 60 years. Prior to that time, there really was not an awful lot that a physician could do for the sick except give them a good deal of sympathy and promote the natural consequences of whatever illness the patient had.

"This type of medical care promoted large doses of the physician's personality because there was not too much else he could offer the patient. As a result of this individual endeavor, a spirit of competition is something that is a legacy of the medical profession. As the fact that we really could cure disease became more and more apparent, it became necessary for teams of doctors, nurses, technicians and ancillary personnel to work together in ever-more complex and ever-more expensive environments. But as has been suggested, competition is a known American virtue and rugged individualism is a hallmark of the medical profession. I think that in many ways, these virtues have become misapplied and that the history of medical progress in the last fifty years is the history of cooperation.

"What we are being asked to do is to signify our belief that cooperation is a sign of medical progress and not just a financial expedient. We are also being challenged to prove that two institutions can produce an offspring that is greater than the two originators. I cannot guarantee that this challenge will be met, but I can guarantee that the people who are recommending this and who have formulated this agreement have been very open, have been very sincere and have really attempted to think of the community first. I have been very impressed by meeting with this committee as to how open things were, how much mutual respect there was and how much primary interest existed in community needs."

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Recently in an interview Dr. Robert Emery, president of the medical staff of the Medical Center of Western Massachusetts, expressed a similar outlook:

"We must all recognize that this is a tremendous challenge, full of tremendous opportunities and possibilities, if we all work together. Cooperation and effort should produce a great medical center, offering every possible modality for the treatment of patients in the hands of well-trained physicians.

"Of course, there will be problems; we anticipate them, and we assess them realistically, knowing that they may not be solved in the near future. For example, the clinical departments and educational programs will have to be consolidated, and this will take time and sacrifice. But as a result, the care of patients will be greatly enhanced. We have the potential to become a great medical center, second to none. This, too, will require sacrifice, time and hard work. And at the same time we must squarely face the potential disadvantage of becoming very impersonal. In this respect we will have to be very careful."

Thus *Baystate Medical Center,* successor of three respected hospitals that were themselves the result of years of unstinting effort on the part of the medical community of Springfield, looks to the future. It would be impossible to list here all those who have made the great sacrifices and contributions that made possible the forerunners: Springfield Hospital Medical Center, Wesson Women's Hospital and Wesson Memorial Hospital; nevertheless, it is to them that we owe a full measure of appreciation.

Joint Committee on Consolidation
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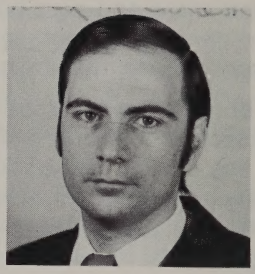
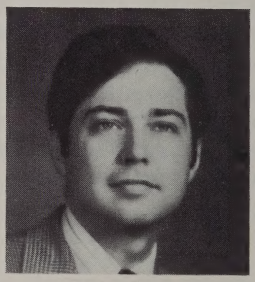
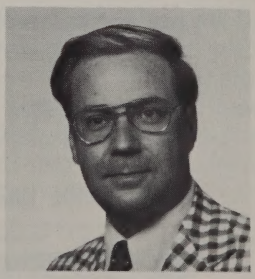


Donald M. Cardone, M.D., 91 School St., Springfield, MA. Born: May 7, 1943. Medical School: New York University, 1969. Internship: Beth Israel Hospital, New York City, N.Y. 1969-70. Residency: Lenox Hill Hospital, Ophthalmology Residency Program, Lenox Hill Hospital, 100 E. 77th St., N.Y.C., N.Y. 1972-75. Specialty: Ophthalmology.



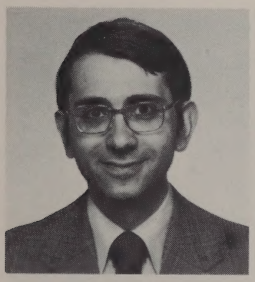
Joseph M. DeCenzo, M.D., 39 Mulberry St., Springfield, MA. Born: August 17, 1944. Medical School: University of Vermont, 1970. Internship: Rush-Presbyterian-St. Luke's Medical Center, Chicago, Ill. 1970-71. Residency: General Surgery (Rush-Presbyterian-St. Luke's Medical Center) 1971-72, 3 Year Urology Medical Center Hospital, Burlington, Vt. 1972-75. Specialty: Urology

Edwin T. Foster, M.D., 1575 Wilbraham Road, Springfield, MA. Born: Sept. 3, 1895. Medical School: St. Louis College of Physicians, 1923. Internship: Presbyterian Hospital, N.Y. 1930-32.



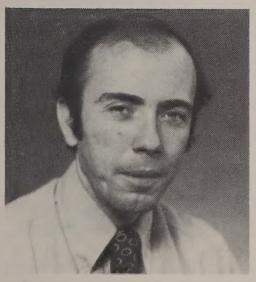
Peter L. Goldman, M.D., 125 Liberty St., Springfield, MA. Born: Nov. 9, 1939. Medical School: Tufts University School of Medicine, 1965. Internship: Surgical July 1965-June 1966. Surgical Residency July 1966-June 1967. Surgeon U.S.S. Hornet July 1967-June 1968. Surgeon U.S. Naval Hospital, Long Beach, Calif. July 1968-June 1969. Residency: July 1, 1969-June 1972, Yale Assistant Resident in Neuro-surgery July 1, 1972-June 30, 1973, Yale Resident in Neuro-surgery July 1, 1973-June 30, 1974, Yale, Chief Resident in Neurosurgery. Specialty: Neurological Surgery.

Marvin L. Hoovis, M.D., Wesson Memorial Hospital, Springfield, MA. Born: April 22, 1929. Medical School: University of Lausanne (Switzerland), 1956. Internship: Coney Island Hospital, Brooklyn, N.Y. 7/1/56-6/30/57. Residency: Coney Island Hospital 7/1/57-6/30/59, St. Mary's Hospital, Waterbury, Conn. 7/1/59-6/30/60, Residency in Internal Medicine. Specialty: Neoplastic Diseases.

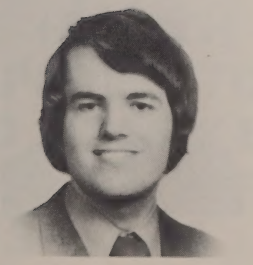


Benjamin A. Kropsky, M.D., 130 Maple St., Springfield, MA. Born: Dec. 13, 1941. Medical School: University of Vermont, 1963. Internship: Sinai Hospital of Baltimore, Inc. 1967-1968. Residency: Montreal General Hospital 1970-1973, Jewish General Hospital, Montreal 1973-1974. Specialty: Internal Medicine.

Geoffrey W. McCarthy, M.D., Mainline Drive, Westfield, MA. Born: Aug. 14, 1941. Medical School: Albany Medical College, 1974. Internship: Albany Medical Center Hospital 1974-75. Specialty: Family Medicine.



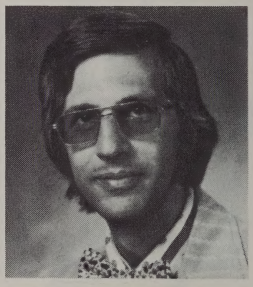
Alan B. Munro, M.D., 10 Hospital Drive, Holyoke, MA. Born: March 2, 1944. Medical School: Dartmouth Medical School 1966, Harvard Medical School 1968. Internship: North Carolina Memorial Hospital 1968-1969. Residency: North Carolina Memorial Hospital 1969-1970, 1974-1975, Fellowship (Cardiology) North Carolina Memorial Hospital 7/70-12/72, 1/73/74. Specialty: Internal Medicine.



William F. Owen, Jr., M.D., Medical Center of Western Massachusetts, 759 Chestnut St., Springfield, MA. Born: Feb. 24, 1949. Medical School: Temple University. Internship: Medical Center of Western Massachusetts July 1973-June 1974. Residency: Medical Center of Western Massachusetts (Internal Medicine) July 1974 to June 1976. Specialty: Internal Medicine.

Meme B. Orquiola, M.D., Springfield Municipal Hospital, 1400 State St., Springfield, MA. Born: Nov. 30, 1939. Medical School: Southwestern University, Philippines 1963. Internship: Frankford Hospital, Philadelphia, Pa., July 1, 1965-June 30, 1966. Residency: General Practice. Residency—Lowell General Hospital 7/1/66 to 6/30/68, Psychiatry—Metropolitan State Hospital, Waltham, MA., July 1, 1968 to Jan. 31, 1969, Internal Medicine—New York VA Hosp. 7/1/69-6/30/70. Specialty: General Practice.

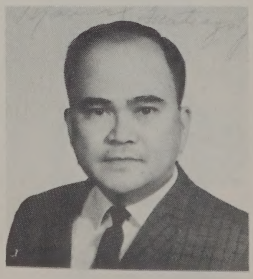
James P. Polga, M.D., 130 Maple St., Springfield, MA. Born: April 18, 1942. Medical School: University of Minnesota, 1966. Internship: Mary Hitchcock Memorial Hospital 1966-67. Residency: Peter Bent Brigham Hospital 1969-72. Specialty: Radiology.



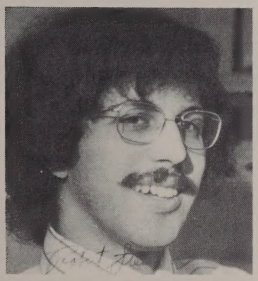
Mandel C. C. F. Rodamilans, M.D., 130 Maple St., Springfield, MA. Born: Sept. 22, 1945. Medical School: Faculdade Medicina Universidade Federal, Bahia, Brasil 1963. Internship: Roger Williams General Hospital, Providence, R.I., Jul. 1, 1970-June 30, 1971 Rot. Internship. Residency: New England M. Center—Boston, Mass., Surg. resident July 1971-June 30, 1972, Springfield Hospital Medical Center surgical residency July 1972-June 30, 1975. Specialty: General Surgery.

(No photo available)

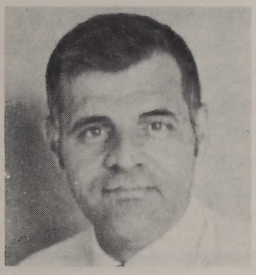
Manuel V. Santiago, Jr., M.D., Holyoke Hospital, Holyoke. MA. Born: July 13, 1930. Medical School: University of Santo Tomas, 1957. Internship: Norwegian-American Hospital, Chicago, Ill., 1958-1959. Residency: Gen. Practice, St. Thomas Hosp., Akron, Ohio, 1959-1961, Anesthesia, 1st yr. New York Medical College 1961-1962, Anesthesia 2nd and 3rd yr. Huron Road Hospital Cleveland, Ohio 1962-1964. Specialty: Anesthesia.



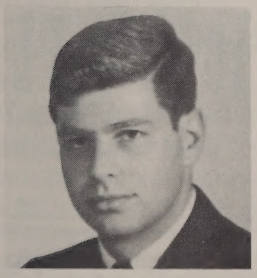
John P. Sorrentino, M.D., 130 Maple St., Springfield, MA. Born: Oct. 27, 1943. Medical School: New Jersey College of Medicine 1969. Internship: St. Vincent Hospital, Worcester, MA. 1969-1970. Residency: State University of New York, Upstate Medical Center, Syracuse, N.Y., 1972-1975. Specialty: OB/GYN.



Robert A. Stein, M.D., Wesson Memorial Hospital, 140 High St., Springfield, MA. Born: May 10, 1944. Medical School: University of Alabama, 1969. Internship: Brooklyn Jewish Hospital, Brooklyn, N.Y. 1969-1970. Residency: Strong Memorial Hospital, University of Rochester, Rochester, N.Y. 1970-1974. Specialty: Radiation Therapy.



James R. Stull, M.D., 179 Walnut St., Holyoke, MA. Born: Dec. 7, 1926. Medical School: Jefferson, Philadelphia, 1957. Internship: Mercy Hospital, Springfield, Ohio, 1958. Residency: Ohio State University Hospital, 1969. Specialty: General Surgery and Family Practice.



Stephen M. Wittenberg, M.D., 80 Congress St., Springfield, MA. Born: Oct. 22, 1935. Medical School: New York University School of Medicine, 1961. Internship: Yale-New Haven Hospital, New Haven, Conn., 7/61-6/62. Residency: Yale-New Haven Hospital, New Haven, Conn., 7/62-6/64. Specialty: Internal Medicine-Cardiology.

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FEATURED ARTICLE

P.L. 93-641
The "National Health Planning and Resources Development Act of 1974"

By Robert J. Woolrich
Review Coordinator
Western Massachusetts Health Planning Council, Inc.

ED'S NOTE: PRESENTED AT THE NOVEMBER 25th HDMS MEETING.

I am pleased to have the opportunity to highlight the provisions of the "National Health Planning and Resources Development Act of 1974," P. L. 93-641. The timing for this discussion is very propitious, as the agencies to be created under this law are in their formative stages. Therefore, there still is an opportunity to insure adequate input into the formative process by all concerned parties. It will be possible for us to continue to develop a truly cooperative health planning effort in Western Massachusetts.

Before I begin discussing the law, it might be useful to explain, briefly, the circumstances which led to its creation.

Following the Second World War, and continuing through the fifties and sixties, a number of laws were passed by Congress which were intended to improve the availability and accessibility of health services to the American people. The best known of these laws are the Hill-Burton Act and the Medicare program. These acts were tremendously successful at achieving their purpose. Data collected since their inception demonstrate that more people are receiving more health care than ever before.

Unfortunately, other data demonstrate with equal clarity that the cost of that health care is skyrocketing. The causes for these increases are manifold. They include a rise in operating costs, increases in personnel costs, rapid technological advancement, increased demand upon the system, skyrocketing malpractice premiums and, of course, inflation.

Concern that these rising costs would limit individual access to the health care system, along with the increasingly larger amount of federal dollars being spent on health care led to the passage of the first health planning act in 1967. It was hoped that through a system of voluntary cooperation between government, providers and consumers, the rapid rise in health costs could be slowed, or even reversed.

For a variety of reasons—ranging from lack of adequate funding to lack of positive incentives for cooperation—the health planning efforts begun under this law were only minimally effective. Consequently, the present legislation was written to assure that the agencies created under its aegis would have both the resources and the tools needed to carry out its intent.

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P. L. 93-641 sets up a tripartite structure: a national health planning council; state health planning and development agencies; and health systems agencies. Additionally, the Congress established national health priorities, including: 1) "The provision of primary care services for medically underserved populations"; 2) "The development of multi-institutional systems for coordination or consolidation of institutional health services"; 3) the development of medical group practices . . . (HMOs), and other organized systems for the provision of health care"; 4) "The training and increased utilization of physician assistants"; 5) "The development of multi-institutional systems for the sharing of support services"; 6) "Activities to achieve needed improvements in the quality of health services"; 7) "The development of health service institutions of the capacity to provide various levels of care . . . on a geographically integrated basis"; 8) "The promotion of activities for the prevention of disease"; 9) "Adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems"; and 10) "The development of effective methods of educating the general public" about health and health services.

To carry out these mandates, the Congress directed that the nation be divided into health service areas. This was to be done by the governor of each state or, if he should fail to do so, by the Secretary of HEW. In Massachusetts, six health areas were selected by the governor. HSA Region I, the local planning area, consists of Berkshire, Franklin, Hampden and Hampshire counties, plus eight Worcester County towns. The activities of the health systems agencies in these six regions are to be coordinated by the state health planning and development agency which, in Massachusetts, will be located in the Department of Public Health. In addition to its coordinating role, the state agency will be responsible for determining priorities for health care in Massachusetts, and for providing support and technical assistance to the local agencies. Its activities will be directed by a state health coordinating council whose members shall be both appointed by the governor, and drawn from nominees selected by the local agencies.

It was the clear intent of Congress that the planning done under this legislation be within the framework of local needs and desires, taking into consideration national and state priorities. Consequently, the local agencies to be created—the health systems agencies—have been strengthened

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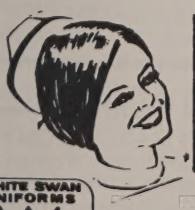
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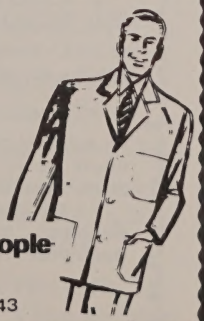

considerably, and the scope of their responsibilities has been broadened. It will be required that they be truly consumer dominated (more about this later), that their workings be accomplished in a truly open fashion, and that their activities be based on a well-reasoned plan for the development of local health care resources.

This latter point is so crucial that many of the functions of an HSA are restricted until such time as a health systems plan has been adopted and approved. Thus, the initial activity of HSAs will be geared toward the completion of this plan.

In developing the plan, the HSA must first inventory available resources, and ascertain the health problems—both real and perceived—which exist in its area. These must then be analyzed to determine the nature of the real problems which exist. When this determination has been made, programs must be designed which will specify goals and objectives which will lead to solving, or at least relieving, the problems. The health systems plan will be a long-range plan (probably five years), and it must be periodically updated.

Accompanying the long-range plan, the HSA must also develop a short-range (one year) plan. This plan —the annual implementation plan— will direct the activities of the HSA on a yearly basis. It will establish priorities to be met within the area each year in an attempt to meet the goals established in the long-range plan.

Both of these plans must be developed in a thoroughly public manner. There are two purposes for this requirement. The first is to assure that the people of the area —both consumers and providers—have adequate opportunity to assist in determining the directions which the agency will take in allotting available resources. It is not intended that HSAs should be paternalistic directors of local activity. Rather, they must serve as vehicles to allow local populations to express their needs and desires.

The second reason for the public nature of these plans is that they will serve as the basis for the use of the tools which the HSAs will have at their disposal for the development of health resources. As such, their contents must be known to the people of the area and—particularly—to local providers of health services, who will be obligated to conform to their mandates.

These tools are of two types: the review functions which HSAs will have, and the health development fund which will be made available by each HSA. These are the carrot and

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the stick which will lend force to the HSA's health plan.

Initially, the review function will be the most noticed of these tools. Each HSA will be required to review and approve or disapprove each expenditure of federal dollars for institutional health services in its area. This is intended to deal basically with the development of institutional health services, and with the creation or continuation of federally funded programs. The HSA will review and approve or disapprove the expenditure of funds appropriated under the Public Health Service Act, the Community Mental Health Centers Act, and the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. (Certain types of funding having been excluded from review for approval, and will only be reviewed for comment by the HSA; e.g., expenditures for manpower training.)

In order to perform this function, each HSA will be required to review all institutional health services in its area for "appropriateness." (I regret that, at present, the word "appropriateness" is not defined. It is intended to deal with such issues as duplication of services, availability and accessibility, cost of services and quality of services. It appears that final definition of this crucial word will have to await some practical review experience.) The first such reviews must be completed within three years of an HSA's initial designation. Thereafter, each institutional service must be reviewed at least every five years. Services which are deemed to be "inappropriate" will not receive federal health dollars. Thus, this review for "appropriateness," combined with the long and short-range plans, will play a major role in determining the results of reviews for approval or disapproval of federal expenditures for health care in the area.

Finally, each HSA will have at its disposal a health development fund. This fund, in Western Massachusetts, will amount to some $800,000 per year. Its purpose is to encourage and assist in the development of needed health services. It may not be used for construction, purchase of equipment, or salaries of persons directly involved in the delivery of health care. It is, basically, seed money. No project may be funded through it for more than two years. The exact uses of this fund are still somewhat unclear, but it is intended to assist in achieving the goals set out by the health systems plan. Unfortunately, these funds will not be available to the HSAs before July 1, 1977.

In carrying out these functions, the HSA will be directed by a board composed of at least 51% consumers and at least 40% providers. Of the providers, at least 1/3 must be direct providers; i.e., physicians, dentists, nurses, etc. Furthermore, the board of directors must be broadly representative of the geographic and socio-economic characteristics of the area.

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The maximum number of members to the board is thirty. Thus, there must be at least 16 consumers and at least four direct providers. The law is quite firm and specific on these points.

Likewise, it is quite specific in its definition of who is a provider. In addition to members of the obvious professions, providers include members of boards of health institutions or organizations, persons who work for health insurers, individuals who own stock in pharmaceutical or other health industries, persons who receive more than 10% of their gross family income from the provision of health services, or spouses or members of the household of such individuals. Members of the medical professions are direct providers. All other providers are indirect providers.

The rules and regulations for implementation of P.L. 93-641 require that each classification of provider—direct and indirect—have representation on the HSA Board. There are at least twelve such provider classifications. With a limit of fourteen provider seats on the board, it thus becomes impossible for the HSA to accommodate every group desiring membership. To deal with this consideration, the HSAs will be required to develop a rotation system which will allow each interested group to have an opportunity to serve on the board.

A similar rotation system will be required to assure that various consumer classifications attain representation.

This should not, however, be interpreted to mean that participation in HSA activities will be restrictive. Through the use of subarea advisory councils and committees, a broader base of involvement can—and should—be achieved. Remember that this law stresses the importance of *local* health planning efforts. Such efforts cannot be strong unless all segments of the community feel committed to the area health plan. Such a commitment can only be attained by involving all elements in the process, and by keeping the process open at all times. Thus, the involvement of all interested parties at all times is crucial to the performance of an HSAs functions. Without this involvement, local planning efforts must fail.

This, I am convinced, would be disastrous. I believe this because I am convinced that the failure of local efforts will not lead to the extinction of

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health planning. Rather, it will lead to statewide or nationwide planning efforts. The federal interest in such planning will continue to expand along with federal expenditures for health care. If the planning is done from afar, its basis will be statistical norms. Since few communities fit such norms precisely, we all stand to lose if local planning cannot be made to work. This is especially true here in Western Massachusetts, where our population is relatively small, and where the statistical characteristics are often quite different than state and national equivalents. The HSAs must, therefore, receive strong local support and input.

This is the most important point I wish to make and the one which I wish to leave with you. HSAs —now, as they develop, and in the future as they perform their functions —need your support. I believe that this visual monologue could be the beginning of a useful and necessary exchange of ideas. Through such an interaction, we can develop an HSA which is responsive to the needs of the people of Western Massachusetts, guided and supported by the health professionals of the region and capable of demonstrating that, through the cooperative efforts of concerned individuals, local health planning *can* work.

Robert J. Woolrich
WMHPC, Inc.

* * *

Letter to the Editor

To the Editor:

I note with pleasure your recognition of Vivian Purdy who will be honored by being listed in the 1975-1976 edition of the "Who's Who of American Women." After reviewing her impressive resume, I note an important omission. Mrs. Purdy was the original Executive Director of the Health Care Foundation of Western Massachusetts, Inc. and the Western Massachusetts P.S.R.O., Inc. Without her dedication and leadership, these organizations would have been considerably delayed in their development.

Mrs. Purdy deserves additional recognition for her involvement and commitment to these organizations as well as to those many others which are listed in her resume.

Sincerely,
Charles E. Everett
Executive Director
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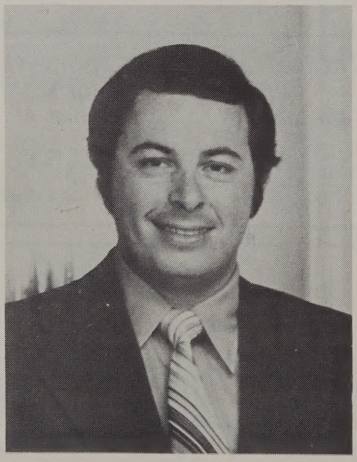

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FEATURED ARTICLE

A little boy struck by a car screaming in pain; a 40-year old with severe chest pains afraid he is dying; what will happen to these and the hundreds of other residents of your communities that need emergency medical services? In Massachusetts alone, it is estimated that about 20% of the over 20,000 heart attack deaths annually could be saved; at least 15% of the 1,000 automobile accident fatalities could be saved and approximately 10% of all other deaths could be prevented by the establishment of an effective system of delivery of emergency medical care.

Massachusetts has begun to assess and improve this ability to respond to medical emergencies. Efforts have been under way for several years in Massachusetts with Federal Financial support. Over 1,000 citizens in the Commonwealth are involved in Regional and State committees to identify needs and develop programs in each of the five EMS subsystem components. These components are: Transportation, Communications, Medical Facilities, Training, and Public Education.

Passage of a landmark Ambulance Bill in the fall of 1973 was one of the most important steps towards improving Emergency Medical Care in Massachusetts. The new law is one of the most comprehensive in the nation and gives the Massachusetts Department of Public Health broad authority to develop Emergency Medical Services in Massachusetts. The law authorizes the Department of Public Health to establish and administer minimum standards for ambulance services, vehicles, equipment, and personnel. Rules and Regulations for this law spell out in detail the required standards and procedures.

For EMS planning purposes, the State of Massachusetts has been broken down into 28 areas. Western Massachusetts contains three of these areas: Berkshire, Hampden and Hampshire and Franklin.

Medical facilities and their emergency departments are the central focus of an emergency medical care system. Like each of the components in the system, how it responds to a serious illness or injury, can mean the difference between recovery and death. It is the hospital with its specialized personnel and equipment around which all the other components in the system must coordinate. Well-trained ambulance and rescue personnel maintain life at the scene and during transportation; communications networks are created; and the public is

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educated for one reason: so that the victim of an unexpected illness or injury may receive definitive and life-saving care in the hospital emergency department. The system operates so as to deliver the victim, in the best possible condition, to a physician who has the right skills and equipment to cope with the person's emergency medical needs.

This, then, is why emergency department physicians, hospital administrators and emergency department nurses from the acute care hospitals in Western Massachusetts have been working together to discuss their care capabilities in the six emergent categories: High risk infant, trauma, cardiac, burns, psychiatric and alcohol and drug overdose.

Because of the obvious geographic differences, each of the fourteen acute care hospitals in Western Massachusetts are unique in many ways. Yet, each must work together to form the basis of an intricate Emergency Medical Services System.

Transportation is the second EMS system component. The goals of the EMS Transportation system may be stated as follows. That in response to a medical crisis or call for help, a vehicle designed exclusively to carry at minimum two trained emergency medical technicians (EMT's), as well as necessary and sophisticated life support equipment should be dispatched immediately. The victim should be cared for and transported without delay to the appropriate medical facility. Other trained personnel and specialized equipment should be dispatched or available on the scene as is required by the medical situation. The EMS transportation service must be ready and available on a 24-hour basis and plan for specific cases of mutual assistance and support if needed.

There are approximately fifty ambulance services in Western Massachusetts. Services are classified according to ownership and generally fall into one of the following categories: volunteer, proprietary and municipal. Each type, by its very nature, has different concerns and needs. EMS transportation is a high priority matter in each community. Life itself may ride on the decision made by community leaders. However, the allocation of public resources to local EMS has been woefully small when compared to per capita police and fire allocations. Good quality EMS transportation requires solid public commitment.

Training is an integral part of the EMS system. It is the trained professional who personifies the system. Trained persons render emergency assistance to a victim both on the scene and while traveling to a medical facility. While it is important for those responding to the aid of the sick and injured to have the desire and willing-

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ness to help, this alone is not enough. Too often, the results of rescue attempts by someone who means well, but lacks formal emergency training, have been harmful and sometimes is irreversibly damaging to the victim.

It is now generally accepted that medical stabilization and support enroute to the medical facility saves more lives than speed alone from the scene to a medical institution. With the advent of the 81 hour Emergency Medical Technician-Ambulance Program, the basic training of ambulance personnel has become standardized nationwide. Prior to this program, training ranged from none at all to Red Cross First Aid and, in a few places, to advanced technician level training. The EMT-A course combines classroom learning with practical instruction and in-hospital training, and certification depends on passage of the Standardized National Registry Exam for Emergency Medical Technicians.

A Registered Emergency Medical Technician is a trained person who has the opportunity to serve as the most valuable lay member of the medical care team outside the hospital. He assesses the nature and extent of illness and injury and establishes priority for required emergency care in the field. He renders emergency care, such as opening and maintaining airway, giving positive pressure ventilation, cardiac resuscitation, controlling of hemorrhage, treatment of shock, immobilization of fractures, bandaging, assisting in childbirth, management of mentally disturbed patients, and he constantly observes the patient enroute to the medical facility, administering additional care as directed by a physician.

Approximately thirty-five EMT-A courses have been offered in Western Massachusetts to date. Additional courses will be offered in the coming year. These courses are sponsored by DPH-OEMS to improve the training of ambulance personnel.

While the training of ambulance personnel is important, all others (i.e. doctors, nurses, other paramedical personnel) involved in the treatment of the acutely ill and injured need specialized training. Until recently, emergency medicine was treated no differently than other generalized aspects of medicine. Now, however, some medical schools have developed a specialty in emergency medicine, and the American Nurses Association has officially recognized Emergency Nursing as a specialty.

However, even with the availability of well equipped transport vehicles and highly trained technicians and coordinated medical facilities, a quality emergency medical services system cannot be realized without a smoothly functioning communications network. Communications is the backbone of an EMS system. Without the unifying effect of a good commu-

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nications system, the other components must operate without means of coordination and control.

An effective EMS communications system will provide hospital-to-hospital and ambulance-to-hospital communications. This will allow the ambulance direct contact to the hospital as soon as the EMT-A's are on the scene. This will also provide direct hospital-to-hospital contact in case of disaster. This system is in the process of being implemented now.

Perhaps the most vital part of EMS communications is the manner in which the public gains access to the system. No matter how excellent the EMS system is, it is useless if the public cannot easily gain access to it. Implementation of the universal Emergency Telephone number (911) can do just that. The caller simply dials 911. A consumer call for help reaches a trained medical technician who dispatches the call to that emergency service most appropriate to meet the caller's need.

The Berkshires, in Western Massachusetts, has the first county-wide communications system in the state. A total of 20 private, public and volunteer ambulance services in Berkshire County are outfitted with radio equipment which links them to the four county hospitals. This system was purchased with federal funds and developed through the work of the volunteer Area 1 EMS Committee along with Western Massachusetts Health Planning Council staff.

The last, but most vital, component of an EMS system is Public Education. Any system offering a service to the public is only effective when the people it intends to serve know how to utilize it. It is safe to say that the level of public knowledge of emergency medical services is fragmented and uneven, where it exists at all. Use of hospital emergency departments as a substitute for the family doctor is as much a problem in Western Massachusetts as elsewhere in the nation. The universal emergency telephone number is only available to one-third of the Region's population. The other half million residents, as well as thousands of visitors, must locate separate telephone numbers for needed services.

Another piece of legislation with great impact on Emergency Medical Services Development is the Federal Emergency Medical Services System Act of 1973 (Public Law 93-154). This act details what is required to receive Federal funds and appropriates large sums of money for EMS planning, research and implementation over the next three years. It is through this act that Massachusetts has received 1.8 million dollars for EMS development in fiscal year 75 and another unstated amount in fiscal 76.

The State EMS program is coordinated by the Department of Public Health, Office of Emergency Medical Services in conjunction with eight Regional Comprehensive Health Plan-

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ning Agencies. The overall goal of the program is to reduce the number of accidents which result in death. This goal requires improvements in both personnel and equipment; and the development and implementation of a coordinated system.

How many of you know how to contact your local ambulance service? What will you do until the ambulance arrives? It could mean the difference between life and death.

Now in Western Massachusetts . . . . . when a cry for help comes into the fire, police, ambulance or rescue company, the response in the near future will be immediate and effective. The thin line that separates success from failure, life from death is being strengthened.

Gary Bunce and
Karen Wakefield
Western Mass. Health Planning
Council

A Philosophic for Living Up-Hill.

Does the road wind up-hill all the way?
Yes, to the very end.
Will the day's journey take the whole long day?
From morn to night my friend.

But is there for the night a resting-place?
A roof for when the slow dark hours begin.
May not the darkness hide it from my face?
You cannot miss that inn.

Shall I meet other wayfarers at night?
Those who have gone before.
Then must I knock, or call when just in sight?
They will not keep you standing at the door.

Shall I find comfort, travel-sore and weak?
Of labor you shall find the sum.
Will there be beds for me and all who seek?
Yea, beds for all who come.

—*Christina G. Rossetti.*

A voice from the past.

The Editor's grandmother sent this to him on the death of her husband and his grandfather. It was found in his mother's clippings of her husband and his father's death, on the day of her death.

W. E. S.

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THE PAGE OF THE HDMS'S WOMAN'S AUXILIARY

The Christmas tea was held on December 9 and it was a huge success. Our thanks are extended to Mrs. William Sheehan who worked so hard planning the event; and to, Mrs. Harvey Grant who allowed us to use her lovely home.

Mrs. Richard Miller wants to remind all Auxilians of the annual Valentine Party on February 14 at the Municipal Hospital. We hope to be able to give each patient a small new gift at the party. There are over 400 patients hospitalized there. If you have any small gift for a man or woman (stationery, comb, playing cards, magnifying glass etc.) please call Mrs. Richard Miller at 567-3698 or Mrs. Robert H. Nenninger at 567-1913. They will be glad to pick the gifts up. Remember the gift need not be big—just a small remembrance to brighten a shut-in's day.

Mrs. Robert H. Nenninger (Pat)

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